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MAINE EMS MEDICAL DIRECTION AND PRACTICE BOARD (MDPB)  
MINUTES  
MEMS CONFERENCE ROOM  
JUNE 17, 1998

Members present: Drs. Chagrasulis, Stuchiner, Grimmritz, Boyink, Liebow

MEMS Staff: D. White

Guests: R. Bumps, J. LeBrun, J. Regis, D. Carroll

I. Previous minutes were reviewed and accepted.

II. Protocol Review

A. Blue (3) - Use of Epinephrine for Adult Asthma

Discussion - literature reviewed contributes information that epinephrine can be helpful in difficult asthma cases, and is not contraindicated for adults, although certainly its use in patients with known CAD would be with great caution.

**Action/Follow-up:** Add: epinephrine 1:1000 0.3 cc subcutaneous to options for adult asthma.

B. Gold - Medical (Dr. Liebow)

**Discussion** - see action/follow-up for summary.

Dr. Liebow presented thorough information on possible changes.

Discussion primarily involved the use of D50 for coma and diabetic emergencies. The MDPB feels that IV Dextrose should only be used if blood glucon has been measured and is documented to be less than 80 mg%.

In that respect, a glucometer would be required equipment if IV dextrose is to be administered.

Regarding Gold 5 (seizures), it was decided that even though Ativan is used preferentially over Valium by some physician providers, the pharmacology is such that to add another drug would be too difficult considering there is no great advantage to its use.

**Action/Follow-up:**

- 1) Gold (1) - add "local measures" to remove toxin.
- 2) Gold (3) - 10.13 change to **"if BG < 80.mg % Dextrose 25. gm IV"**.
- 3) Gold (4) - 9.A. change to "If BG < 80mg %, administer dextrose 25gm IV".
- 4) Change to "repeat glucose measurement".
- 5) Dr. Chagrasulis to send memo, along with proposed protocol changes, that glucometers are required in order to be able to administer Dextrose IV. Additional education via Journal of Maine EMS, CQI Reviews, etc.

C. Green - Trauma (Dr. Stuchiner)

Discussion: Green 2 - 2. discussion regarding which medical control is meant by OLMC. It was decided to add "local" OLMC to avoid confusion. Put "telephone" by "local OLMC" to reinforce that local medical control needs to be contacted in order to divert to RTC. Otherwise, no change in wording.

Also, the Trauma Advisory Committee should discuss a statewide mechanism for a "code" system for traumas which may need transport to RTC.

Green (5) - Spinal Injury Protocol - Discussion primarily on ongoing CQI Review to assess proper use of protocol, potential effects on outcome, etc. Educational issues need to be addressed. Actual change to protocol is only to change the title to "Spinal Assessment Protocol". For other, see "action/follow-up".

Green 7, 8, & 9 - more adjacent to trauma 1, 2, & 3.

Green 10 - add "or other MEMS - approval device".

Green 13 - MAST - eliminate from protocol; not to be required equipment.

Green 17 - 3A "May Repeat per medical control if indicated".

**Action/Follow-up:**

- 1) Green 2 - Change to "Local OLMC", add telephone.
- 2) Green 5 - Change title to "Spinal Assessment Protocol" Refer to State CQI/Data Committee the need to monitor compliance with use of protocol  
Refer to education committee concerns over continued retraining or spinal Injury Management Article, JOMEMS when disseminating new protocol changes, emphasize spine management issues.
- 3) Green 7, 8, & 9 - move adjacent to Green 1, 2, 3
- 4) Green 10 - ad "or other MEMS approved device".
- 5) Green 13 - MAST - eliminate change (Rules) to not required equipment
- 6) Green 17 - 3.A "May repeat per medical control if indicated"

7) Letter from Dr. Chagrasulis to Trauma Advisory Committee regarding a "code" system for trauma triage patients.

D. Yellow - Dr. Boyink

Discussion - Toxins

Initially, no proposal change, but discussion since June meeting via e-mail regarding use of activated charcoal. Change need for medical control to be contacted for use of activated charcoal by all levels. Add "poison control to be contacted if possible by pre hospital personnel" so that specific information on toxin can be faxed to ED prior to patient's arrival.

Dr. Burton relayed extensive discussion from MMC on hypothermia, following a very difficult case (Yellow 9). If submersion greater than one hour, survivability is virtually nil. Therefore, pre hospital providers could prevent unnecessary transports and provide definitive direction at the scene (through protocol) that is greater than one hour submersion resuscitative measures are fruitless.

**Action/Follow-up:**

1) add to Yellow 1 "contact poison control for information on toxin"

2) Yellow 2 - add telephone for use of charcoal at all license levels

3) Yellow 9 -Hypothermia

BLS/ALS procedures and transports should not be initiated. . .

4) Yellow 9

Delete "core temperature less than 60F"

Delete "these procedures significantly delay evacuation to controlled rewarming".

Delete "BLS/ALS procedures should be discontinued or deferred. . . "

Continue page 9 with "Note . . . "

III. Lifeflight of Maine Protocols

**Discussion:** Thus far, MDPB members have not received a copy of these protocols, which are currently under development. Drs. Stuchiner and Burton have been active in protocol development. Because the MDPB will not meet in July and August, these protocols will be sent to all MDPB members as soon as they become available, and review can be ongoing with discussions via e-mail.

**Action/Follow-up:** Send protocols to all MDPB members when finalized, and communicate via e-mail over the summer.

Meeting adjourned. Next MDPB meeting September 17, 1998, at 9:30 a.m., MEMS Board Room.

Submitted,

Rebecca Chagrasulis, MD